FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0013896

Facility Name: St Matthew Lutheran Home

Address: 1601 N. Western Ave. (Number) Park Ridge (City) 60068 (Zip Code)

County: Cook

Telephone Number: (847) 825-5531 **Fax #** (847) 318-6659

IDPA ID Number: 36-2584799-001

Date of Initial License for Current Owners: 1959

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C)(3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Erica Mazurowski **Telephone Number:** (847) 635-4648

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 8/19/1999

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3	63	Intermediate (ICF)	56	20,839	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	183	TOTALS	176	64,759	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		27,261	2,864	30,125	8
9	SNF/PED					9
10	ICF	16,517			16,517	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,517	27,261	2,864	46,642	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.02%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started / /1959

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 19 and days of care provided 2,864

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	346,354	33,328	63,645	443,327		443,327		443,327			1
2	Food Purchase		261,763		261,763		261,763	(6,387)	255,376			2
3	Housekeeping	101,480	32,983		134,463		134,463		134,463			3
4	Laundry	50,366	4,858	62,793	118,017		118,017		118,017			4
5	Heat and Other Utilities			142,463	142,463	1,639	144,102		144,102			5
6	Maintenance	108,713	9,160	88,721	206,594	2,374	208,968		208,968			6
7	Other (specify):*			16,669	16,669	847	17,516		17,516			7
8	**TOTAL General Services**	606,913	342,092	374,291	1,323,296	4,860	1,328,156	(6,387)	1,321,769			8
	B. Health Care and Programs											
9	Medical Director			11,000	11,000		11,000		11,000			9
10	Nursing and Medical Records	2,275,787	162,337	38,647	2,476,771		2,476,771		2,476,771			10
10a	Therapy	40,200		104,920	145,120		145,120		145,120			10a
11	Activities	134,555	6,068	14,619	155,242		155,242		155,242			11
12	Social Services	90,460	206	15,920	106,586		106,586		106,586			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,541,002	168,611	185,106	2,894,719		2,894,719		2,894,719			16
	C. General Administration											
17	Administrative	67,643			67,643	126,281	193,924		193,924			17
18	Directors Fees											18
19	Professional Services			473,961	473,961	(266,493)	207,468	33,934	241,402			19
20	Dues, Fees, Subscriptions & Promotions			40,128	40,128	21,020	61,148	(21,393)	39,755			20
21	Clerical & General Office Expenses	213,762	17,985	68,523	300,270	37,599	337,869		337,869			21
22	Employee Benefits & Payroll Taxes			793,701	793,701	18,302	812,003		812,003			22
23	Inservice Training & Education					2,099	2,099		2,099			23
24	Travel and Seminar			16,045	16,045		16,045	(1,580)	14,465			24
25	Other Admin. Staff Transportation					5,805	5,805		5,805			25
26	Insurance-Prop.Liab.Malpractice			23,405	23,405	7,168	30,573		30,573			26
27	Other (specify):*	28,808			28,808	88	28,896	(28,896)				27
28	**TOTAL General Administration**	310,213	17,985	1,415,763	1,743,961	(48,131)	1,695,830	(17,935)	1,677,895			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,458,128	528,688	1,975,160	5,961,976	(43,271)	5,918,705	(24,322)	5,894,383			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number St Matthew Lutheran Home #0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			247,254	247,254	18,477	265,731	1,941	267,672			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			203,167	203,167	4,832	207,999	(285)	207,714			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds					16,441	16,441		16,441			34
35	Rent-Equipment & Vehicles			22,957	22,957	3,521	26,478	(3,282)	23,196			35
36	Other (specify):*											36
37	**TOTAL Ownership**			473,378	473,378	43,271	516,649	(1,626)	515,023			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,624	96,624		96,624		96,624			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			96,624	96,624		96,624		96,624			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,458,128	528,688	2,545,162	6,531,978		6,531,978	(25,948)	6,506,030			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,387)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(285)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(28,896)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	10,405			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,163)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,155)	35	34
35	Other- Attach Schedule	370		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (785)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (25,948)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

St Matthew Lutheran Home

ID# 0013896

Report Period Beginning: 7/01/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Allowable, Mgmt, HR & Service Net Alloc	$ 33,934	19	1
2	Awards & Grants	(957)	20	2
3	Mgmt Auto Depreciation	(556)	30	3
4	Adjust in depr for IDPA adjustments	370	30	4
5	Advertising & Promotion - Program	(20,436)	20	5
6	Out of State Travel & Seminar	(1,580)	24	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
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87				87
88				88
89				89
90	**Total**	10,775		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,387)	0	0	0	0	0	0	0	0	0	0	(6,387)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,387)	0	0	0	0	0	0	0	0	0	0	(6,387)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	33,934	0	0	0	0	0	0	0	0	0	0	33,934	19
20	Fees, Subscriptions & Promotions	(21,393)	0	0	0	0	0	0	0	0	0	0	(21,393)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,580)	0	0	0	0	0	0	0	0	0	0	(1,580)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(28,896)	0	0	0	0	0	0	0	0	0	0	(28,896)	27
28	**TOTAL General Administration**	(17,935)	0	0	0	0	0	0	0	0	0	0	(17,935)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(24,322)	0	0	0	0	0	0	0	0	0	0	(24,322)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(186)	2,127	0	0	0	0	0	0	0	0	0	1,941	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(285)	0	0	0	0	0	0	0	0	0	0	(285)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(1,155)	(3,282)	0	0	0	0	0	0	0	0	0	(4,437)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,626)	(1,155)	0	0	0	0	0	0	0	0	0	(2,781)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(25,948)	(1,155)	0	0	0	0	0	0	0	0	0	(27,103)	45

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Vesper Management	Des Plaines, IL	Mgmt. Co.
				Luthera Social Service	Des Plaines, IL	Corporate Office
N/A	N/A	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		35	IS Loan Equipment Rental	$ 3,282	Vesper Management Corp	100.00%	$	$ (3,282)	1
2	V		30	Depreciation		Vesper Management Corp	100.00%	2,127	2,127	2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 3,282			$ 2,127	$ * (1,155)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	N/A										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Avenue, Suite 50
City / State / Zip Code: Des Plaines, Illinois 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	28,067,775	270	$ 997,148	$ 997,148	1,389,955	$ 49,380	1
2	22	Empl Benefits & Taxes		28,067,775	270	162,007		1,389,955	8,023	2
3	19	Prof Fees & Contracts		28,067,775	270	3,858,301		1,389,955	191,068	3
4	21	Supplies, Telephone,		28,067,775	270	602,840		1,389,955	29,853	4
5		Postage, Out. Printing		28,067,775	270	0		1,389,955	0	5
6	34	Rental of Space		28,067,775	270	326,630		1,389,955	16,175	6
7	5	Utilities		28,067,775	270	32,855		1,389,955	1,627	7
8	6	Bldg Repairs & Maintenance		28,067,775	270	5,767		1,389,955	286	8
9	32	Interest		28,067,775	270	80,455		1,389,955	3,984	9
10	33	Real Estate Taxes		28,067,775	270	0		1,389,955	0	10
11	26	Insurance		28,067,775	270	143,300		1,389,955	7,096	11
12	27	Advertising & Promotions		28,067,775	270	1,767		1,389,955	88	12
13	25	Transportation		28,067,775	270	49,754		1,389,955	2,464	13
14	35	Car Rental		28,067,775	270	5,801		1,389,955	287	14
15	23	Conferences & Conventions		28,067,775	270	33,047		1,389,955	1,637	15
16	20	Subscriptions, Dues, Awards		28,067,775	270	18,746		1,389,955	928	16
17	21	Furniture & Fixtures		28,067,775	270	11,663		1,389,955	578	17
18	6	Machinery & Equipment		28,067,775	270	1,311		1,389,955	65	18
19	35	Equipment Rental		28,067,775	270	43,153		1,389,955	2,137	19
20	6	Equipment Repair & Maint		28,067,775	270	36,299		1,389,955	1,798	20
21	20	Employee Recruitment		28,067,775	270	50,702		1,389,955	2,511	21
22	7	Security & Waste Removal		28,067,775	270	17,105		1,389,955	847	22
23	21	All Other Miscellaneous		28,067,775	270	10,264		1,389,955	508	23
24	30	Depreciation		28,067,775	270	304,634		1,389,955	15,086	24
25	TOTALS					$ 6,793,549	$ 997,148		$ 336,426	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	47,987,195	270	$ 633,120	$ 633,120	4,255,328	$ 56,143	1
2	22	Empl Benefits & Taxes		47,987,195	270	90,256		4,255,328	8,004	2
3	19	Prof Fees & Contracts		47,987,195	270	142,094		4,255,328	12,600	3
4	21	Supplies, Telephone,		47,987,195	270	58,353		4,255,328	5,175	4
5		Postage, Out. Printing		47,987,195	270			4,255,328		5
6	34	Rental of Space		47,987,195	270	2,998		4,255,328	266	6
7	5	Utilities		47,987,195	270	138		4,255,328	12	7
8	6	Bldg Repairs & Maintenance		47,987,195	270	536		4,255,328	48	8
9	32	Interest		47,987,195	270	4,714		4,255,328	418	9
10	33	Real Estate Taxes		47,987,195	270			4,255,328		10
11	26	Insurance		47,987,195	270	688		4,255,328	61	11
12	27	Advertising & Promotions		47,987,195	270			4,255,328		12
13	25	Transportation		47,987,195	270	27,210		4,255,328	2,413	13
14	35	Car Rental		47,987,195	270	1,022		4,255,328	91	14
15	23	Conferences & Conventions		47,987,195	270	2,737		4,255,328	243	15
16	20	Subscriptions, Dues, Awards		47,987,195	270	164,037		4,255,328	14,546	16
17	21	Furniture & Fixtures		47,987,195	270			4,255,328		17
18	6	Machinery & Equipment		47,987,195	270			4,255,328		18
19	35	Equipment Rental		47,987,195	270	11,348		4,255,328	1,006	19
20	6	Equipment Repair & Maint		47,987,195	270	1,991		4,255,328	177	20
21	20	Employee Recruitment		47,987,195	270	31,485		4,255,328	2,792	21
22	7	Security & Waste Removal		47,987,195	270			4,255,328		22
23	21	All Other Miscellaneous		47,987,195	270	165		4,255,328	15	23
24	30	Depreciation		47,987,195	270	33,178		4,255,328	2,942	24
25	TOTALS					$ 1,206,070	$ 633,120		$ 106,952	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

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Street Address: 1001 E. Touhy Avenue, Suite 50
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Phone Number: (847) 635-4600
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	4,236,824	2	$ 63,273	$ 63,273	1,389,955	$ 20,758	1
2	22	Empl Benefits & Taxes		4,236,824	2	6,935		1,389,955	2,275	2
3	19	Prof Fees & Contracts		4,236,824	2	140		1,389,955	46	3
4	21	Supplies, Telephone,		4,236,824	2	3,902		1,389,955	1,280	4
5		Postage, Out. Printing		4,236,824	2			1,389,955		5
6	34	Rental of Space		4,236,824	2			1,389,955		6
7	5	Utilities		4,236,824	2			1,389,955		7
8	6	Bldg Repairs & Maintenance		4,236,824	2			1,389,955		8
9	32	Interest		4,236,824	2	1,312		1,389,955	430	9
10	33	Real Estate Taxes		4,236,824	2			1,389,955		10
11	26	Insurance		4,236,824	2	35		1,389,955	11	11
12	27	Advertising & Promotions		4,236,824	2			1,389,955		12
13	25	Transportation		4,236,824	2	2,830		1,389,955	928	13
14	35	Car Rental		4,236,824	2			1,389,955		14
15	23	Conferences & Conventions		4,236,824	2	667		1,389,955	219	15
16	20	Subscriptions, Dues, Awards		4,236,824	2	732		1,389,955	240	16
17	21	Furniture & Fixtures		4,236,824	2			1,389,955		17
18	6	Machinery & Equipment		4,236,824	2			1,389,955		18
19	35	Equipment Rental		4,236,824	2			1,389,955		19
20	6	Equipment Repair & Maint		4,236,824	2			1,389,955		20
21	20	Employee Recruitment		4,236,824	2	10		1,389,955	3	21
22	7	Security & Waste Removal		4,236,824	2			1,389,955		22
23	21	All Other Miscellaneous		4,236,824	2	573		1,389,955	188	23
24	30	Depreciation		4,236,824	2	1,368		1,389,955	449	24
25	TOTALS					$ 81,777	$ 63,273		$ 26,827	25

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Tax Exempt Bonds		X	Refinance Building Additions	N/A	9/23/93	$ 1,286,188	$ 2,525,429	08/15/20	0.0738	$ 203,167	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Mgmt Alloc (per Sch. VIII)	X		Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	4,832	6
7												7
8												8
9	TOTAL Facility Related						$ 1,286,188	$ 2,525,429			$ 207,999	9
	B. Non-Facility Related*											
10												10
11	Interest Income			Offset against interest expense	N/A	N/A	N/A	N/A	N/A	N/A	(285)	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (285)	14
15	TOTALS (line 9+line14)						$ 1,286,188	$ 2,525,429			$ 207,714	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 82,510 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	203,354	1958	$ 38,704	1
2					2
3	TOTALS	203,354		$ 38,704	3

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1959	1959	$ 444,500	$	40	$	$	$ 444,500	4
5			1966	1966	315,066	7,898	40	7,898		271,798	5
6	176		1976	1976	2,205,040	55,277	40	55,277		1,350,663	6
7			1976	1976	24,547	615	40	615		14,738	7
8			1977	1977	13,438	337	40	337		7,895	8
	Improvement Type**										
9	1978 Addition			1978	1,780		10			1,780	9
10	1979 Addition			1979	5,380		10			5,380	10
11	1983 Addition			1983	2,142		10			2,142	11
12	1984 Addition			1984	11,139		10			11,139	12
13	1985 Addition			1985	2,400		10			2,400	13
14	1986 Addition			1986	7,692		10			7,692	14
15	1987 Addition			1987	291,787	14,629	20	14,629	(0)	196,976	15
16	Renovations			1989	268,451		10			268,451	16
17	ADJUSTMENT PER IDPA - 1989 Renovations			1989	(22,714)		10			(22,714)	17
18	ADJUSTMENT PER IDPA - 1988 Costs			1988	14,914		10			14,914	18
19	Aluminum Awning			1989	1,400	9	10	9	(0)	1,400	19
20	Canopy / Western ave.			1991	30,720	1,232	25	1,232	(0)	10,450	20
21	Panasonic Camera System			1991	3,720		5			3,720	21
22	New Sidewalk			1991	2,500	250	10	250		2,192	22
23	Concrete Loading dock			1991	6,690	671	10	671	0	5,775	23
24	Bathroom Remodeling			1992	13,440	1,348	10	1,348	0	10,086	24
25	Chapel Renovation			1992	40,511	4,062	10	4,062	(0)	30,388	25
26	Generator & Mechanical Work			1993	43,564	4,368	10	4,368	(0)	28,335	26
27	New Roof West Building			1993	208,807	20,938	10	20,938	0	135,810	27
28	Generator Projct & electrical			1993	146,296	14,670	10	14,670	0	95,153	28
29	Upgrade West Building Electrical			1993	19,029	1,908	10	1,908	(0)	12,377	29
30	Alzeheimer Unit			1993	125,598	12,594	10	12,594	(0)	81,690	30
31	ADJUSTMENT PER IDPA - Alzeheimer Unit			1993	(6,025)		10	(602)	(602)	(4,218)	31
32	ADJUSTMENT PER IDPA - 1990 Improvements OHF			1990	19,450		10	972	972	19,450	32
33	Parking Lot Lighting			1993	17,300	1,735	10	1,735	0	11,247	33
34	Shower Room Renovation			1994	9,455	948	10	948	(0)	5,204	34
35											35
36	TOTAL (lines 4 thru 35)				$ 4,268,017	$ 143,489		$ 143,859	$ 370	$ 3,026,813	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1983	1983	$ 150,179	$	10	$	$	$ 150,179	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Rehab Area Renovation			1994	56,031	5,618	10	5,618		30,840	9
10	Air Conditioning - West Bldg			1995	32,823	3,291	10	3,291		17,077	10
11	Air Conditioning Project - #95-056			1995	5,423	544	10	544		2,465	11
12	ADA Elevator Upgrade			1995	5,548	556	10	556		2,497	12
13	Air Conditioner - Laudry Room			1997	842	84	10	84		231	13
14	Fence & Installation			1997	674	68	10	68		185	14
15	Kitchen A/C & Installation			1997	17,500	2,508	7	2,508		6,872	15
16	Installation of Fire Doors			1997	4,897	196	25	196		506	16
17	Landscape Materials			1998	1,600	160	10	160		347	17
18	Retainers - Int. Design			1998	3,085	309	10	309		617	18
19	Interior Design Fees			1998	1,349	135	10	135		247	19
20	Interior Design Fees			1998	3,000	301	10	301		549	20
21	Construction Project			1998	11,282	1,131	10	1,131		1,876	21
22	Painting & Staining			1998	13,725	1,376	10	1,376		2,282	22
23	Painting & Staining			1998	13,723	1,376	10	1,376		2,282	23
24	4-two way radios			1998	904	91	10	91		150	24
25	HVAC/Electrical Upgrade			1998	6,482	650	10	650		1,025	25
26	New Roof			1998	170,700	6,847	25	6,847		13,076	26
27	Wall & Door Install - Décor			1999	2,850	286	10	286		380	27
28	Furniture - Décor Proj			1999	9,010	903	10	903		1,202	28
29	Architecture, Electrical			1999	10,602	1,063	10	1,063		1,415	29
30	Windw Replacement			1999	4,765	478	10	478		636	30
31	Energy Study & Admin			1999	1,948	195	10	195		260	31
32	HVAC & Admin			1999	3,325	333	10	333		444	32
33	Glass Top for Desk			1999	200	20	10	20		25	33
34	Carpet Installation			1999	125,765	12,611	10	12,611		15,712	34
35	MDC Wallcovering			1999	4,400	441	10	441		550	35
36	TOTAL (lines 4 thru 35)				$ 662,633	$ 41,574		$ 41,574	$	$ 253,927	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Add-Ons for Lobby Window			1999	1,800	181	10	181		225	9
10	Install Wood Veener			1999	894	90	10	90		112	10
11	Paint Sprinkler Pipes			1999	120	12	10	12		15	11
12	Executive Chair - bldg décor project			1999	313	31	10	31		37	12
13	Water Cooling system			1999	108,000	4,334	25	4,334		4,675	13
14	Pedestal Desk - bldg décor project			1999	3,120	313	10	313		338	14
15	Air Conditioning			1999	446	18	25	18		19	15
16	Copies- bldg décor project			1999	50	5	10	5		5	16
17	Air Conditioning			1999	6,000	602	10	602		649	17
18	Glass repair - bldg décor project			1999	2,659	266	10	266		266	18
19	Westwood lamp and Cocktail			1999	1,075	108	10	108		108	19
20	Remodel 6 resident rooms			1999	720	72	10	72		72	20
21	120L/F/Roppe & Johnson			1999	170	17	10	17		17	21
22	Installation of Awnings			1999	8,307	551	10	551		551	22
23	Couch Wallcovering			2000	61	3	10	3		3	23
24	Installation of Awnings			2000	241	10	10	10		10	24
25	Installation of new windows			2000	35,200	1,167	10	1,167		1,167	25
26	Electric Upgrade			2000	16,253	258	5	258	(0)	258	26
27	Facility Upgrade			2000	82,732	657	10	657	(0)	657	27
28	Air Conditioning project			2000	43,000	137	25	137	0	137	28
29	Facility Upgrade			2000	3,886		10				29
30	Door & Wall Repairs			2000	3,280	10	25	10		10	30
31											31
32											32
33	FY 89 IDPA Audit - Phone System Amplifiers			1989	491		5			491	33
34	FY 89 IDPA Audit - Garbage Disposer			1989	2,654		5			2,654	34
35	FY 89 IDPA Audit - Ceiling Fans			1989	2,724		7			2,724	35
36	TOTAL (lines 4 thru 35)				$ 324,196	$ 8,840		$ 8,840	$ (0)	$ 15,199	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	FY 89 IDPA Audit - Toilet Frames			1989	734		5			734	9
10	FY 89 IDPA Audit - Air Conditioner			1989	993		5			993	10
11	Management Assets - Security System			1999	222		10	47	47	N/A	11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,949	$		$ 47	$ 47	$ 1,727	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 357,644	$ 32,530	$ 43,156	$ 10,626	Various	$ 147,261	37
38	Current Year Purchases	115,415	18,055	25,303	7,248	Various	18,055	38
39	Fully Depreciated Assets	463,799	2,766	2,766		Various	463,799	39
40								40
41	TOTALS	$ 936,858	$ 53,351	$ 71,225	$ 17,874		$ 629,115	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Transp.	1990 Ford Paratransit Van	1990	$ 36,850	$	$	$	7	$ 36,850	42
43										43
44										44
45										45
46	TOTALS			$ 36,850	$	$	$		$ 36,850	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 6,269,207	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 247,254	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 265,545	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 18,290	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 3,963,631	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	1990 Dodge Caravan 1990	$ 13,609	$	$ 13,609	52
53	Truck Cover 1988	775		775	53
54	1988 Dodge Sweptline P.U.	10,040		10,040	54
55	Management Autos	3,881		N/A	55
56					56
57	TOTALS	$ 28,305	$	$ 24,424	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 19,675 Description: Copy Machine rental, flexiboots
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18	N/A				18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	N/A			
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	N/A
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits	N/A						6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number St Matthew Lutheran Home **#** 0013896 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)			3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,160,386	1
2	Discounts and Allowances for all Levels	(59,534)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,100,852	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	6,387	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 6,387	23
	D. Non-Operating Revenue		
24	Contributions	16,781	24
25	Interest and Other Investment Income***	285	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 17,066	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	1,748	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,748	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,126,053	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,323,296	31
32	Health Care	2,894,719	32
33	General Administration	1,743,961	33
	B. Capital Expense		
34	Ownership	473,378	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	96,624	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,531,978	40
41	**Income before Income Taxes (line 30 minus line 40)****	594,075	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 594,075	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,659	1,864	$ 50,004	$ 26.83	1
2	Assistant Director of Nursing	1,781	1,941	44,983	23.18	2
3	Registered Nurses	45,977	52,041	953,548	18.32	3
4	Licensed Practical Nurses	76,407	86,550	854,176	9.87	4
5	Nurse Aides & Orderlies	35,310	38,905	340,867	8.76	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,626	4,113	40,200	9.77	8
9	Activity Director	1,779	1,985	30,680	15.46	9
10	Activity Assistants	10,072	10,964	103,875	9.47	10
11	Social Service Workers	3,265	3,845	66,693	17.35	11
12	Dietician	344	369	6,262	16.97	12
13	Food Service Supervisor	7,871	9,100	121,538	13.36	13
14	Head Cook	5,643	6,099	49,199	8.07	14
15	Cook Helpers/Assistants	21,429	23,622	169,355	7.17	15
16	Dishwashers					16
17	Maintenance Workers	7,121	8,049	108,713	13.51	17
18	Housekeepers	13,336	14,030	101,480	7.23	18
19	Laundry	5,289	6,010	50,366	8.38	19
20	Administrator	1,766	2,018	67,643	33.52	20
21	Assistant Administrator					21
22	Other Administrative	2,980	3,624	66,668	18.40	22
23	Office Manager					23
24	Clerical	11,649	12,986	147,094	11.33	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,421	3,730	32,209	8.64	31
32	Other Health Care(specify)					32
33	Other(specify)	2,455	2,895	52,575	18.16	33
34	TOTAL (lines 1 - 33)	263,180	294,740	$ 3,458,128 *	$ 11.73	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 61,510	1,3	35
36	Medical Director	As Needed	11,000	9,3	36
37	Medical Records Consultant	As Needed	14,732	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	1,200	10,3	39
40	Physical Therapy Consultant	As Needed	65,420	10a,3	40
41	Occupational Therapy Consultant	As Needed	21,459	10a,3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	18,041	10a,3	43
44	Activity Consultant	As Needed	7,476	11,3	44
45	Social Service Consultant				45
46	Other(specify) (see attached)	As Needed	68,761	various	46
47	Legal & Audit/Accounting	As Needed	30,518	19,3	47
48	Laundry Services	As Needed	62,793	4,3	48
49	TOTAL (lines 35 - 48)		$ 362,910		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	As Needed	341	10,3	52
53	TOTAL (lines 50 - 52)		$ 341		53

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Carter	Administrator	0	$ 67,643
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 67,643

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Dickson Wright - Illinois	Legal Fees	$ 770
Freeman, Freeman & Salzman	Legal Fees	1,400
RSM McGladrey Inc.	Medicare Cost Report Prep.	14,938
Frost, Ruttenberg & Rot	Medicare Consultation	13,410
LSSI	Management Services	436,273
Joint Commission	Survey Fee for LTC Accred.	7,170
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 473,961

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 87,929
Unemployment Compensation Insurance	33,197
FICA Taxes	253,390
Employee Health Insurance	396,738
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	22,447
Management Allocation Benefits (per Sch VIII s)	18,302
TOTAL (agree to Schedule V, line 22, col.8)	$ 812,003

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,611
Health Care Worker Background Check	
(Indicate # of checks performed)	
Licenses & Fees	3,750
Advertising & Promotion, Awards, Grants	21,393
Subscription & Books	3,769
Membership Dues	5,525
Management Allocation (per Sch VIII s)	21,020
Fee for Credentialing Physicians	80
Less: Public Relations Expense	(957)
Non-allowable advertising	(20,436)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,755

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Employee Mileage Payments, Meals Lodging	1,080
Conference & Convention	500
In-State Travel	
Vehicle Operation Cost	588
Employee Mileage Payments	1,969
Meals, lodging	318
Seminar Expense	9,525
Conference & Convention	1,815
Agency Meetings	250
Less Out of State Travel & Seminar	(1,580)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,465

**See instructions.

Facility Name & ID Number St Matthew Lutheran Home # 0013896 Report Period Beginning: 7/01/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10	N/A												
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number St Matthew Lutheran Home # 0013896 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Life Services Network $5,245**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **40,488** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **96,624**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **YES** Indicate the amount. $ **6,387**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **YES**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **CLIFTON GUNDERSON, LLC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **In progress, will send when available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.